KENTUCKY BOARD OF **02/20/02**
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
P. O. BOX 1360
FRANKFORT, KY 40602
http://slp.ky.gov

APPLICATION FOR INTERIM LICENSURE
SPEECH-LANGUAGE PATHOLOGY ASSISTANT

Fill in the blanks: print or type. All information requested must be supplied on the form. If an item is not applicable to you, complete the blank with "none" or "N/A". If insufficient space is provided for any item, attach supplemental sheets.

Your application should be accompanied by a check or money order of **fifty (50) dollars** made payable to ***Kentucky State Treasurer***. **DO NOT SEND CASH.** A copy of your official transcript is also required to be sent directly from the educational institution to the Board. Photocopies or transcripts issued to students are not acceptable.

1. PERSONAL DATA:

NAME: _____ S.S. NO. _____

NAME AS IT APPEARS ON TRANSCRIPT: _____

ADDRESS: _____
Street, Apt. #, P.O. Box City State Zip

TELEPHONE: Home ( ) _____ Business ( ) _____

U. S. CITIZEN: ☐ Yes ☐ No If no, have you declared your intention to become a citizen? ☐ Yes ☐ No

DATE OF BIRTH: _____

Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, explain: _____

2. EDUCATION:

School	Names and Locations	Dates Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
UNDER-GRADUATE SCHOOL							
GRADUATE SCHOOL							

3. REGISTRATION AND LICENSURE HISTORY:

A. Do you now or have you ever held a state certification, licensure, or registration to practice speech-language pathology in any state? ☐ Yes ☐ No

B. Have you ever been refused certification, licensure, registration, or the renewal thereof? ☐ Yes ☐ No

C. Have you ever had a certification, license, or registration to practice speech-language pathology revoked, suspended, or otherwise acted against in a disciplinary proceeding? ☐ Yes ☐ No

If 3A is answered "Yes" provide the name of each state and include a photocopy of each certification, license or registration ever held. If 3B or 3C is answered "Yes" you must provide details as to the state, agency or organization, certificate, license or registration number, date and state reason on a supplemental sheet.

4. AFFIDAVIT

In affixing my signature to this application, I hereby swear or affirm that all statements and information provided herein are true and correct to the best of my knowledge, information and belief. Any untrue statement knowingly made by me on this application shall constitute grounds for such disciplinary action as the Board many determine appropriate.

SIGNATURE _____ DATE _____

Do Not Write Below This Line- -For Board and Office Use Only

FEE RECEIPTED
Amount $ _____ Date _____

Lic. No. _____ Date _____

BOARD REVIEW DATE _____
[ ] Approved **[ ]** Denied
Members _____
_____

PLAN OF ACTIVITIES FOR POSTGRADUATE PROFESSIONAL EXPERIENCE

This portion of the application must be completed by the supervisor

1. PPE SETTING:

School System: _____ School Name(s) _____

Address: _____
Street City State Zip Code
Telephone Number: Home ( ) _____ Work ( ) _____

Beginning Date of PPE: _____/_____/_____ Estimated Ending Date: _____/_____/_____

[ ] Full-Time (9 months) **[ ]** Part-Time: _____ hrs/week _____ # weeks

2. SUPERVISOR INFORMATION:

Supervisor Name: _____

Address: _____
Street City State Zip Code

Telephone Number: Home ( ) _____ Work ( ) _____

Place of Employment: _____

[ ] Kentucky License Number: _____ Date Granted: _____ Expiration Date: _____
[ ] KY Teacher Certification No.: _____ Date Granted: _____

(NOTE: A copy of the supervising SLP's Kentucky Teaching Certificate must be attached if he/she does not hold a current speech-language pathology license in Kentucky.)

3. AGREEMENT TO PROVIDE SUPERVISION

I, _____, do hereby agree to provide supervision as required by KRS 334.035 (2) and as defined by 201 KAR 17:025 Section 2 and 201 KAR 17:027 for _____ to function as a speech-language pathology assistant during the period of this license.

I further agree to accept responsibility for the practice and activities of the above named individual in his/her capacity as a speech-language pathology assistant.

I acknowledge that the failure to utilize this person appropriately as a speech-language pathology assistant and to supervise in accordance with the above cited provisions of Chapter 334A of the Kentucky Revised Statues and the administrative regulations promulgated thereunder, shall be considered as aiding and abetting an unlicensed person to practice speech-language pathology as described in KRS Chapter 334A.

SUPERVISOR'S SIGNATURE: _____ DATE: _____